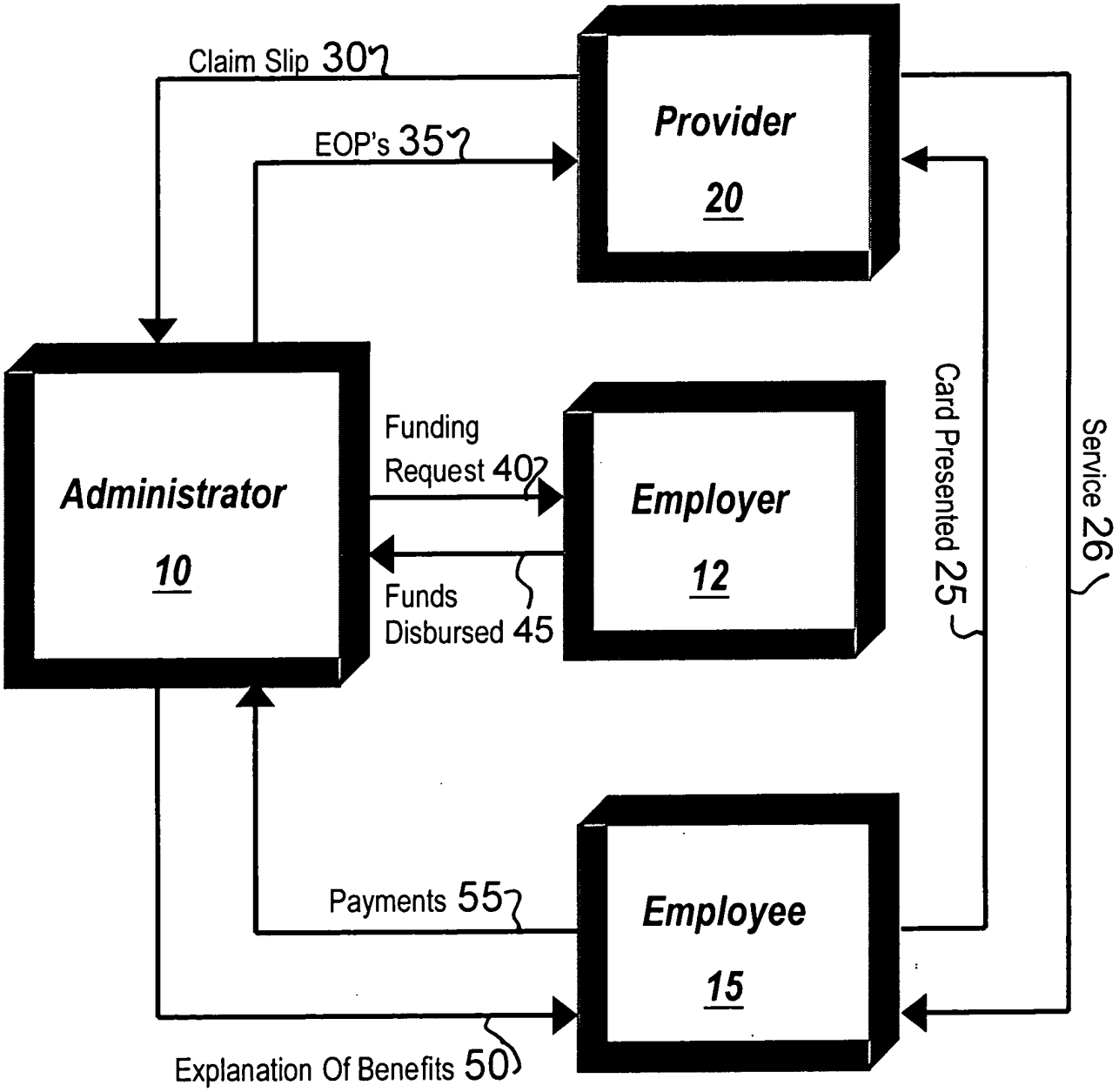
FIG. 1


Claim Slip 30
EOP's 35
Provider
20
Administrator
10
Funding
Request 40
Funds
Disbursed 45
Employer
12
Card Presented 25
Service 26
Payments 55
Employee
15
Explanation Of Benefits 50

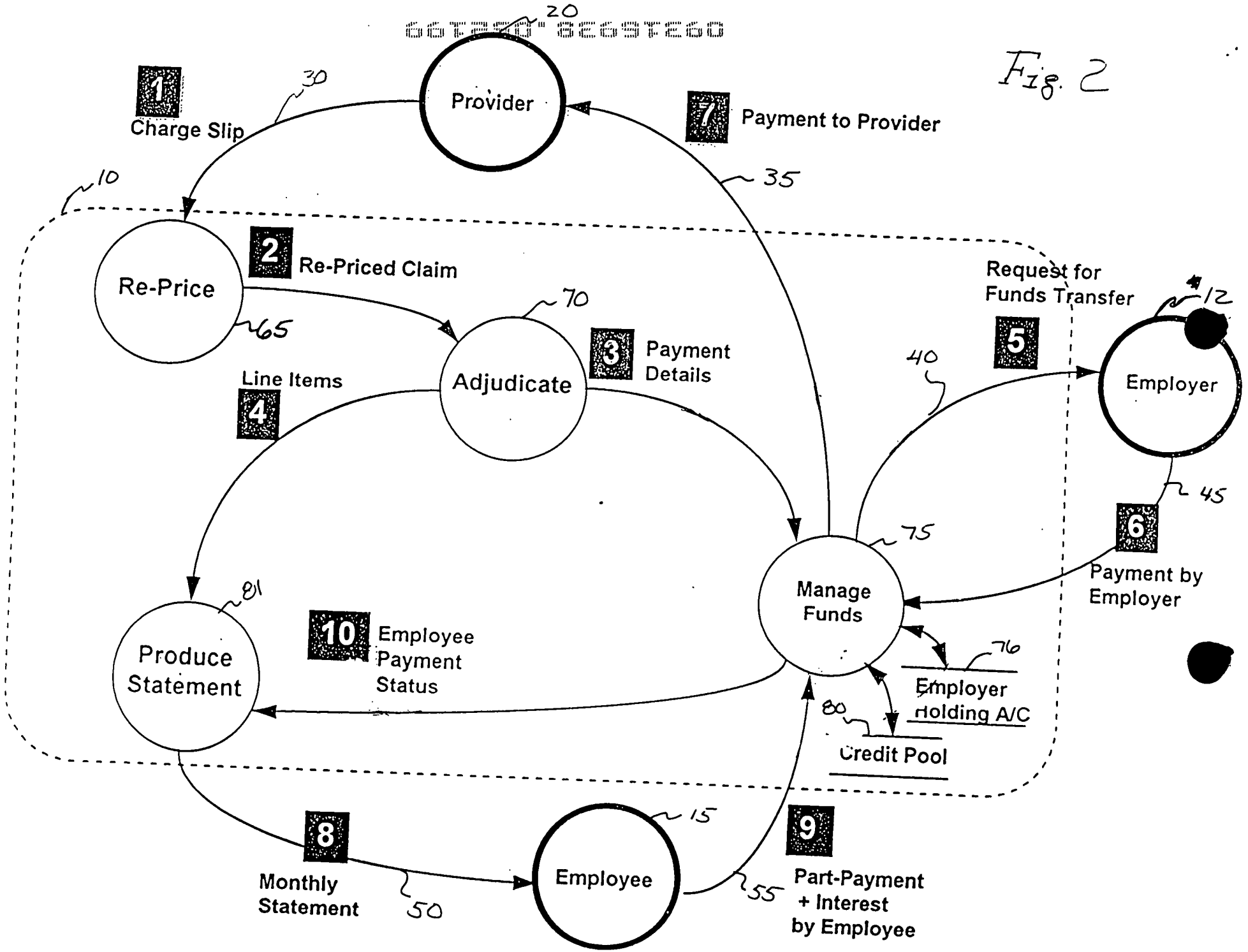

20
Provider
1
Charge Slip
30
7
Payment to Provider
35
10
Re-Price
2
Re-Priced Claim
65
70
Adjudicate
3
Payment
Details
Line Items
4
Request for
Funds Transfer
5
40
Employer
12
45
6
Payment by
Employer
75
Manage
Funds
81
Produce
Statement
10
Employee
Payment
Status
76
Employer
Holding A/C
80
Credit Pool
8
Monthly
Statement
50
15
Employee
9
Part-Payment
+ Interest
by Employee
55

Fig. 2

FIGURE 3a.

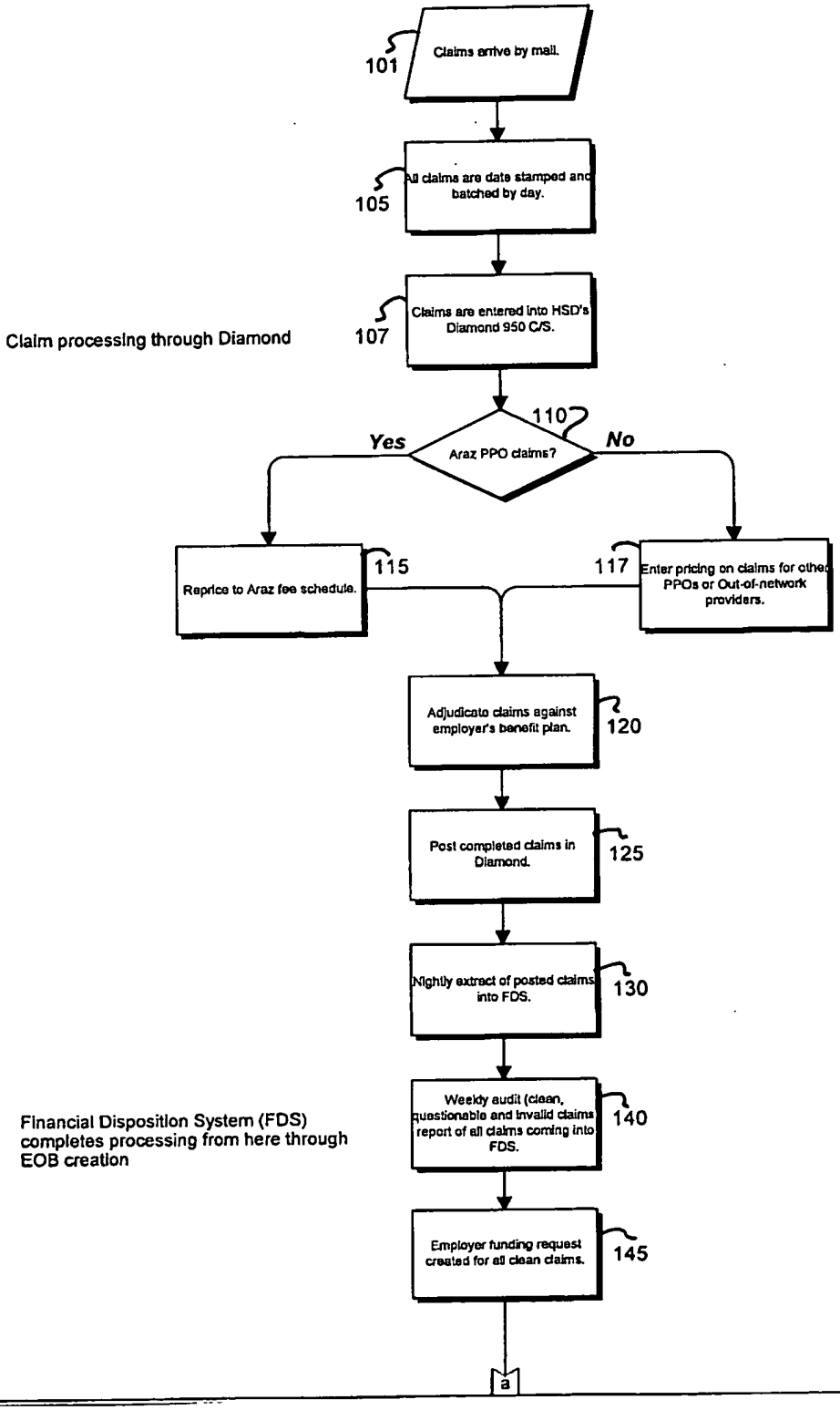

Claim processing through Diamond
101
Claims arrive by mail.
105
All claims are date stamped and batched by day.
107
Claims are entered into HSD's Diamond 950 C/S.
110
Araz PPO claims?
Yes
No
115
Reprice to Araz fee schedule.
117
Enter pricing on claims for other PPOs or Out-of-network providers.
Adjudicate claims against employer's benefit plan.
120
Post completed claims in Diamond.
125
Nightly extract of posted claims into FDS.
130
Financial Disposition System (FDS) completes processing from here through EOB creation
Weekly audit (clean, questionable and invalid claims report of all claims coming into FDS.
140
Employer funding request created for all clean claims.
145
a

FIGURE 3b.

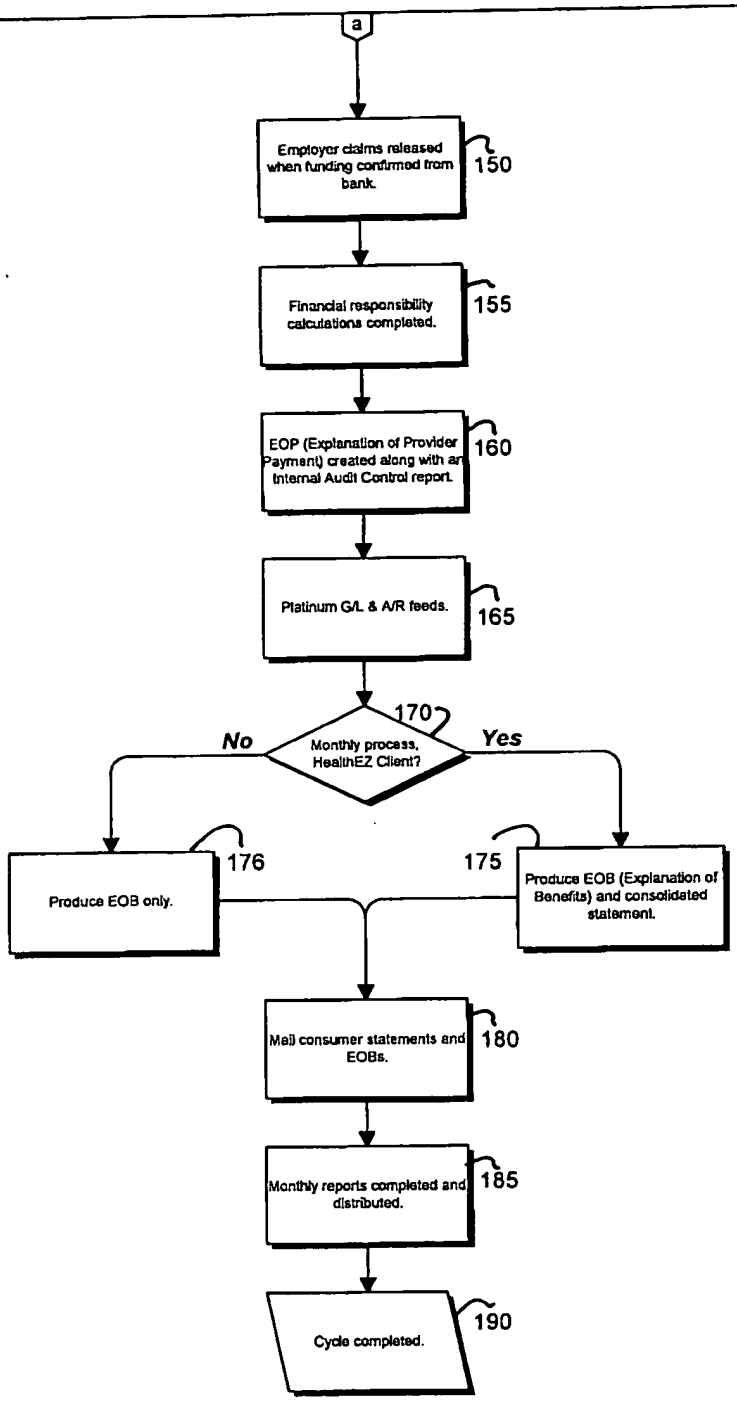

a
Employer claims released when funding confirmed from bank.
150
Financial responsibility calculations completed.
155
EOP (Explanation of Provider Payment) created along with an Internal Audit Control report.
160
Platinum G/L & A/R feeds.
165
170
Monthly process, HealthEZ Client?
No
Yes
Produce EOB only.
176
175
Produce EOB (Explanation of Benefits) and consolidated statement.
Mail consumer statements and EOBs.
180
Monthly reports completed and distributed.
185
Cycle completed.
190

FIGURE 4a.

A [redacted] 31

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

20. OUTSIDE LAB? YES | NO | $ CHARGES

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

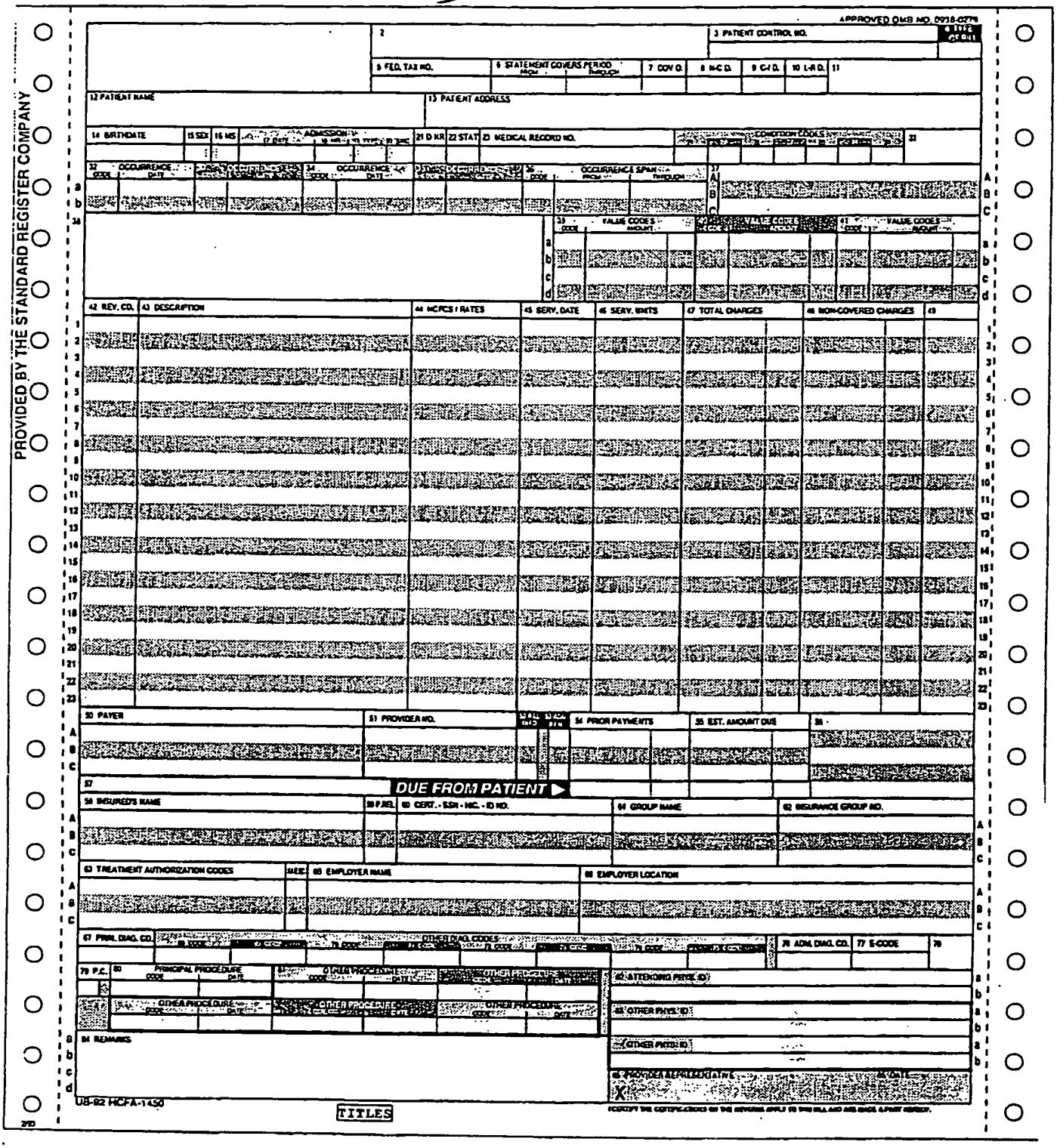
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CH

30 FIGURE 46

32



ADMINISTRATOR'S NAME AND ADDRESS

FIG: 5

PROVIDER'S NAME and ADDRESS

May 6, 1999
Check # 6759
Payment Amount: $105.39

Explanation of Payment

Patient Account #	Patient Name (First, Last)	Service Date(s)	Service Code(s)	Units	Billed Charges	Network Discount	PPO	Contract Amt	Non-Covered Benefit	Other	Payment from HealthEZ	Patient Owes	Claim Number
199[redacted]101C	[redacted]	03/29/99	95115	1	21.00	5.00	ARZ	16.00	0.00	0.00	16.00	0.00	13965[redacted]
ALLERGY & ASTHMA SPECIALISTS PA			Claim Totals		$21.00	5.00		$16.00	0.00	$0.00	$16.00	$0.00	
199[redacted]101C	[redacted]	04/01/99	89180	1	27.00	13.84	ARZ	13.16	0.00	0.00	13.16	0.00	13965[redacted]
199[redacted]101C	[redacted]	04/01/99	99214	1	107.00	30.77	ARZ	76.23	0.00	0.00	76.23	0.00	13965[redacted]
ALLERGY & ASTHMA SPECIALISTS PA			Claim Totals		$134.00	44.61		$89.39	0.00	$0.00	$89.39	$0.00	
			Totals		$155.00	49.61		$105.39	0.00	$0.00	$105.39	$0.00	

[redacted]

For questions regarding payment on the above claim (s) direct your inquires to: [redacted]
[redacted]
[redacted], Minnesota [redacted]
Telephone Number: [redacted]

[redacted], INC.
"CLAIMS CLEARING ACCOUNT"
4550 W. 77TH ST., SUITE 240
MINNEAPOLIS, MN 55435-5007

6759

May 6, 1999

PAY TO THE ORDER OF [redacted] VOID $105.39

ONE HUNDRED FIVE AND 39 / 100---------- DOLLARS

[redacted] BANK
[redacted]

FOR _____

<6759< :091014898: 115140:

Funding Request Report

Funding # : 24
Date of Request : 04/22/1999
Group # : 700
Employer :

66T290" 826STE60

FIGURE : 6

141

Vendor

Physician, Clinic or Hospital

Claim #	Date of Service	Billed Amount	HealthEZ Allowed	HealthEZ Discount	Employee Payment	Employer Payment
1090451	08/24/1998	69.50	42.03	27.47	8.41	33.62
1090454	08/24/1998	212.50	170.98	41.52	34.20	136.78
1240836	12/18/1998	352.00	307.30	44.70	61.46	245.84
1262186	01/12/1999	39.00	31.43	7.57	31.43	0.00
1161623	10/26/1998	52.00	52.00	0.00	20.80	31.20
1362612	01/31/1999	68.00	59.49	8.51	59.49	0.00
1332595	02/09/1999	36.00	31.49	4.51	31.49	0.00
1378293	02/07/1999	91.00	91.00	0.00	0.00	91.00
1368611	03/02/1999	42.00	31.43	10.57	6.29	25.14
1380031	03/23/1999	67.00	48.57	18.43	48.57	0.00
1113939	03/23/1998	63.50	63.50	0.00	25.40	38.10
1378338	03/03/1999	46.00	34.30	11.70	34.30	0.00
1367230	03/03/1999	110.75	82.70	28.05	82.70	0.00
1362610	02/12/1999	18.95	16.54	2.41	16.54	0.00
1381278	03/22/1999	200.00	178.48	21.52	162.18	16.30
1135600	10/05/1998	85.00	85.00	0.00	85.00	0.00
1142542	09/28/1998	40.00	31.43	8.57	31.43	0.00
1112141	09/08/1998	39.00	34.30	4.70	6.86	27.44
1139297	10/19/1997	89.10	54.29	34.81	54.29	0.00
1158167	10/23/1998	30.00	22.33	7.67	0.00	22.33
					Total :	667.75

Fig. 7a

PLAN SPONSOR'S LOGO

John Doe
555 Oak Street
Anytown, MN 55555

50

Employee ID number	123-45-6789
Statement date	26-Oct-98
New balance	**90.00**
Credit option minimum payment due	**25.00**
Payment must be received by	**20-Nov-98**
Amount enclosed	$

Please detach and return this coupon with your check payable to HealthEZ, Inc.

Indicate change in address and/or telephone number below:

Street _____

City, State, Zip _____

Phone ( ) _____

(CUT ALONG DOTTED LINE)

New Balance Summary

Previous balance	$	30.00
Payments & credits	$	30.00
New transactions	$	90.00
Finance charges & fees	$	-
New balance as of 10/26/98	$	90.00

Credit Available

Credit limit	$	1,500.00
New balance	$	90.00
Credit available	$	1,410.00

51

Account & Payment Information

Employee name	John Doe
Employee ID number	123-45-6789
Statement date	26-Oct-98
Credit option minimum payment due	**25.00**
Payment must be received by	**20-Nov-98**

Your Resources for Help

(612) 896-5451 [redacted] Customer Service
(888) 588-6516 [redacted] Customer Service

Transactions for the current period:

Payment Date	Patient	Provider/Svc. Date	Claim Summary*		Due to HealthEZ	Due to Provider
10/02/1998	Jane	OB/GYN & Infertility, PA Edina, MN 09/04/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	62.00 -14.40 -32.60 **15.00**	15.00	0.00
10/02/1998	Martha	Metropolitan Pediatrics Edina, MN 09/08/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	46.00 -2.30 -28.70 **15.00**	15.00	0.00
10/09/1998	Susan	Metropolitan Pediatrics Edina, MN 09/08/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	46.00 -2.30 -28.70 **15.00**	15.00	0.00
10/09/1998	John	Aspen Medical Group Minneapolis, MN 09/28/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	212.00 -85.46 -111.54 **15.00**	15.00	0.00
10/16/1998	Robert	South Lake Pediatrics Minnetonka, MN 09/29/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	62.00 -17.11 -29.89 **15.00**	15.00	0.00
10/16/1998	Martha	Metropolitan Pediatrics Edina, MN 10/02/1998	Billed amount HealthEZ discount Employer payment **Employee responsibility**	64.00 -7.00 -42.00 **15.00**	15.00	0.00

Total Due to HealthEZ: $ 90.00

*Please see the following page(s) for your detailed explanation of benefits.

Rates & Fees:

Variable Periodic Rates:

Daily percentage rate (%)		8%
Annual percentage rate (%)	$	-
Average daily balance		30
Number of days in billing cycle		

Finance Charges & Fees:

Interest charge	$0.00

Notes:

1 If you have another health benefit plan which may help you pay your obligations, please call HealthEZ customer service. Please have this statement and the other health plan information available when you call

PLEASE REFER TO REVERSE SIDE FOR YOUR RIGHTS OF REVIEW AND APPEAL AND AN EXPLANATION OF TERMINOLOGY

SAMPLE_eob1_ltrsummary

50 52

Detailed Explanation of Benefits

Patient: JANE

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
OB/GYN & Infertility	1113579												
Office Visit	09/04/1998	48.00	13.70	34.30			15.00		19.30		19.30	15.00	0.00
Tissue Exam	09/04/1998	14.00	0.70	13.30			0.00		13.30		13.30	0.00	0.00
Total		62.00	14.40	47.60			15.00		32.60		32.60	15.00	0.00

Remarks:

Patient: MARTHA

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
Metropolitan Pediatrics	1113575												
Office Visit	09/08/1998	46.00	2.30	43.70			15.00		28.70		28.70	15.00	0.00
Total		46.00	2.30	43.70			15.00		28.70		28.70	15.00	0.00

Remarks:

Patient: SUSAN

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
Metropolitan Pediatrics	1113578												
Office Visit	09/08/1998	46.00	2.30	43.70			15.00		28.70		28.70	15.00	0.00
Total		46.00	2.30	43.70			15.00		28.70		28.70	15.00	0.00

Remarks:

Patient: JOHN

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
Aspen Medical Group	1117563												
Preventive Visit	09/28/1998	135.00	59.00	76.00			15.00		61.00		61.00	15.00	0.00
EKG	09/28/1998	40.00	21.00	19.00			0.00		19.00		19.00	0.00	0.00
Cholesterol	09/28/1998	14.00	3.36	10.64			0.00		10.64		10.64	0.00	0.00
Urinalysis	09/28/1998	12.00	1.55	10.45			0.00		10.45		10.45	0.00	0.00
Hemoglobin	09/28/1998	11.00	0.55	10.45			0.00		10.45		10.45	0.00	0.00
Total		212.00	85.46	126.54			15.00		111.54		111.54	15.00	0.00

Remarks:

Patient: ROBERT

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
South Lake Pediatrics	1113771												
Office Visit	09/29/1998	62.00	17.11	44.89			15.00		29.89		29.89	15.00	0.00
Total		62.00	17.11	44.89			15.00		29.89		29.89	15.00	0.00

Remarks:

Patient: MARTHA

Provider/ Type of service	Claim Number / Service Date(s)	Billed Amount	HealthEZ Discount	Allowed Amount	Not Covered	See Remark	Patient Copay	Patient Deductible	Balance	Employee Responsibility: Patient Coinsurance	Employer Payment	You owe HealthEZ	You owe provider
Metropolitan Pediatrics	1113578												
Preventive Visit	10/02/1998	49.00	5.30	43.70			15.00		28.70		28.70	15.00	0.00
Hemoglobin	10/02/1998	15.00	1.70	13.30			0.00		13.30		13.30	0.00	0.00
Total		64.00	7.00	57.00			15.00		42.00		42.00	15.00	0.00

Remarks

YTD Individual Update

Araz Plan Individual Preferred Provider Out-of-Pocket Amount		Actual YTD Individual Preferred Provider Out-of-Pocket Amount		Araz Plan Individual Non-Preferred Provider Out-of-Pocket Amount		YTD Individual Non-Preferred Provider Out-of-Pocket Amount	
JOHN	1500.00	JOHN	100.00	JOHN	5000.00	JOHN	163.92
JANE	1500.00	JANE	250.00	JANE	5000.00	JANE	325.96
MARTHA	1500.00	MARTHA	175.23	MARTHA	5000.00	MARTHA	175.23
ROBERT	1500.00	ROBERT	83.65	ROBERT	5000.00	ROBERT	83.65
SUSAN	1500.00	SUSAN	52.00	SUSAN	5000.00	SUSAN	52.00

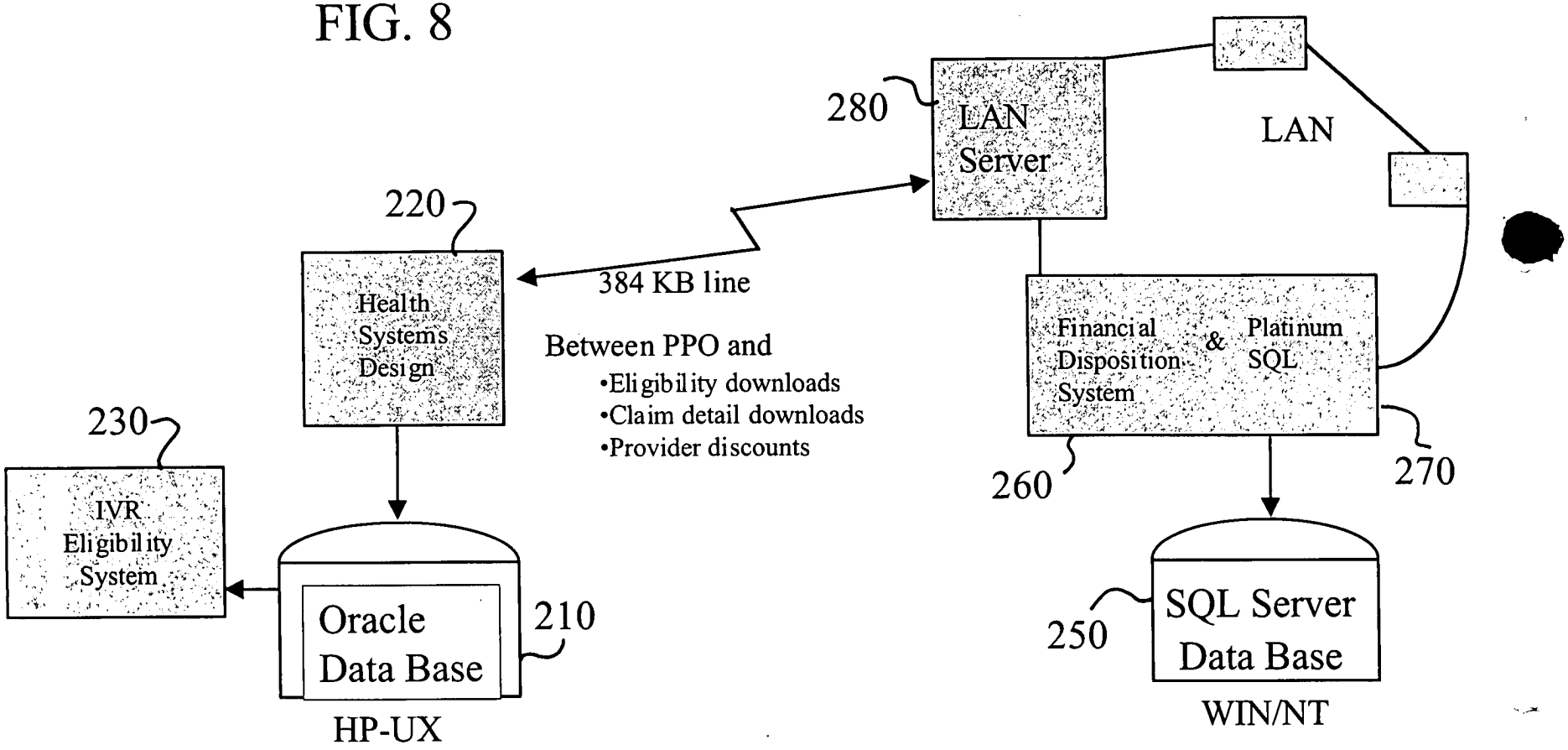
Araz Plan Preferred Provider	3000.00	YTD Family Preferred Provider	660.88
Araz Plan Non-Preferred Provider	7500.00	YTD Family Non-Preferred Provider	800.76

Amount Paid by Employer YTD – For Claims Incurred in 1998	
JOHN	655.68
JANE	1303.84
MARTHA	700.92
ROBERT	334.60
SUSAN	208.00
Family	2547.36

Fig. 76

PLEASE REFER TO REVERSE SIDE FOR YOUR RIGHTS C VIEW AND APPEAL AND AN EXPLANATION OF TERMINOLOGY

FIG. 8



Functional Purpose:

HSD-Diamond 950C/S

- •Enrollment/Eligibility
- •Provider network
- •HealthEZ fee schedules
- •Reprice & adjudicate

FDS

- •Funding verification
- •Credit reserve calc.
- •Provider EOP
- •Provider 1099
- •Statement w/EOB

Platinum SQL Accounting

- •Statement w/EOB
- •Payment processing
- •Dunning letters
- •Internal Accounting
- •Financial analysis